STATE BOARD OF HEALTH

THURSDAY, MARCH 12, 2009

11:00 A.M.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

DIRECTOR'S CONFERENCE ROOM - 5TH FLOOR

535 WEST JEFFERSON STREET

SPRINGFIELD, ILLINOIS

Christina J. Riebeling, CSR, CCR

GOLEMBECK REPORTING SERVICE
Connie S. Golembeck, Owner
(217) 523-8244
(217) 632-8244

MEMBERS PRESENT OF THE STATE BOARD OF HEALTH

KAREN PHELAN, (Chairperson)
CASWELL EVANS, D.D.S., M.P.H.
KEVIN D. HUTCHISON, R.N., M.S., M.P.H.
ANN O'SULLIVAN, R.N., M.S.N.
TIM VEGA, M.D.
HERBERT E. WHITELEY, D.V.M., PH.D.
PETER ORRIS, MD, MPH (VIA TELEPHONE)
JANE L. JACKMAN, MD
JERRY KRUSE, MD, MSPH

ALSO PRESENT:

CLEATIA BOWEN
DAVID CARVALHO
CLAUDIA NASH
PAULA ATTEBERRY
BILL BELL
SEAN DAILEY
SUSAN MEISTER

I N D E X

CHAIRPERSON PHELAN: So the Board has been sent the June 12th and the December 11th minutes. Let's start with the June 12th. Does anyone have any changes to the June 12th? I think I have one. On Page 2, B, the action, I just believe it needs to be adjusted.

[WHEREUPON THERE WAS A SHORT DISCUSSION OFF THE RECORD.]

UNIDENTIFIED SPEAKER: Under which one?

CHAIRPERSON PHELAN: B. Okay. So it's B, action, SBOH voted to send the rule to for publication.

UNIDENTIFIED SPEAKER: Okay.

CHAIRPERSON PHELAN: Does anyone else have any additions?

DR. KRUSE: Well, I think that the meeting took place in Chicago. It says Bilandic building in Springfield, Illinois.

UNIDENTIFIED SPEAKER: Okay. We'll change that.

CHAIRPERSON PHELAN: Okay. Any questions? Concerns? All in favor of approving the minutes?

VARIOUS: Aye.

CHAIRPERSON PHELAN: So approved.

And then we'll move to December 11th. Does

anybody have additions or corrections for that summary?

DR. KRUSE: Same thing. I think it took place in Chicago. At least that's what I remember.

MS. O'SULLIVAN: December, yeah, we were.

UNIDENTIFIED SPEAKER: Yeah, that's true.

CHAIRPERSON PHELAN: Any questions? Any changes? All in favor of approving the meeting summary for December 11th?

VARIOUS: Aye.

CHAIRPERSON PHELAN: Any nays? No? We're good. Okay. Approved December 11th.

Next on the agenda is our Director's remarks.

MR. CARVALHO: The Director is on a flight to Prague and so is unable to give remarks today. We have provided his secretary with your schedule for the rest of the year, and we'll be taking away his passport. As you can see from the minutes, at your last meeting he was in Taipei, and in case you're curious, it is a business trip related to international public health preparedness. And perhaps at the next meeting he can give you a fuller description of his travels.

Since your last meeting, December 11th -- let's see. You had your last meeting several days after the Governor's arrest, and your current meeting is several days before the new Governor's budget address, so you've wedged it right in there. Of course, since your last meeting, former Governor Blagojevich has been removed from office, and Governor Quinn has assumed that office.

I'm sure as most of you know, Governor Quinn has had an interest in health and matters of health over many years, and has been well advised on those matters by, among others, Dr. Quentin Young, who recently celebrated his 85th birthday. And Governor Quinn also has an interest in veterans affairs, and Dr. Arnold and Governor Quinn share both of those interests.

So we're -- over the last five years, since it was also an interest of Governor Blagojevich's, health has generally fared better than some other subjects in the Governor's budgets. We are facing an extraordinarily challenging budget year this year, and we are eagerly anticipating, as I expect you are, to see what the Governor's budget address next Wednesday will bring and what it will mean to, among others,

public health.

We have submitted our budget. We had submitted it several months ago, and we'll not know exactly what it will look like until next week.

In my legislative report, I can give you details of particular bills, and will. But at this point in the remarks, I guess I would point out that, as you know, the legislature is in session and dealing with -- it's the first term of a two-year -- first year of a two-year term, and so everything starts again. Everything that was pending last year that didn't pass is ended, but there is a Republican legislator named Mike -- I can't remember Mike's last name -- in the '80s who used to say, if there is such a thing as reincarnation, I want to come back as a bad idea in Springfield, because then I'll never die.

So we are finding all of the bills that we successfully -- let me put it another way. Many of bills that we were happy to see not adopted in the last session are back again in the current session, and health remains a popular topic to legislate on.

A lot of the activities of the Director over the last couple of months, and as well the agency, have been focused upon public health preparedness.

And in fact, a couple of weeks ago we reached a milestone of sorts where the 40 top administrators within the agency went through a five-day, all day training in something called Incident Command System, and we believe we are probably the first public health agency in the country to do that. We may be the first emergency -- I knew how to do that, you know. Just because I hadn't done, it didn't mean I didn't know how.

In any event, we were all trained in Incident Command System, and so in fact, just to show that I do know how to do this, over here on the wall, for those of you that are familiar with Incident Command System, we have a chart that, you know, starts with the Incident Commander at the top and the whole command staff, as well as the operations sections and the like. So we're in that peculiar situation of now we're all revved up and nowhere to go. We are not looking forward to there being an incident, but we are all trained to deal with one if there is. And as I mentioned, Dr. Arnold's trip to Prague is also preparedness related, and some of our legislative initiatives are also preparedness related.

So I look forward to Dr. Arnold's ability --

being able to meet with this Board at its next meeting and convey his regret that he is on his way to Prague.

While I'm circumnavigating the room, why don't I turn it back over to your temporary chair.

CHAIRPERSON PHELAN: Thank you, David. This is like watching a PowerPoint presentation.

Okay. So next on the agenda, we have -- does anybody have any questions first for David in this portion?

Let's go into the rules committee report. As we all know, David McCurdy is having eye surgery today, and so we'll go on record wishing him a speedy recovery. Dave did chair our meeting on February 26th, where we discussed the three rules, and the summary was provided I believe in your packets, so let's start with the first rule as noted on the agenda. That's the Newborn Metabolic Screening and Treatment. And who will be providing us background today?

MS. NASH: I'm Claudia Nash, and I'm the program manager of the newborn screening program. Basically a law was passed, and this was -- this was actually initiated by consumers, family members who were interested in seeing the newborn screening program add

testing for five lysosomal storage disorders to our screening panel. And we can -- once you put that in there, maybe you can abbreviate it LSD. That's what we're used to doing. So this was passed, I believe, November of '07, and the law actually recognized that no states are screening for these now except New York State is screening for one, which is Krabbe disease, K-R-A-B-B-E.

The reagents necessary for screening for the other disorders are being or were being, actually, I guess -- the quality assurance was being tested on those by CDC. So it was written into the legislation that the Department would not start these screenings until all of the reagents had been approved by CDC and the test methodology approved. And I think it also -- it did state in the legislation that our laboratory would need to be remodeled. So the reagents would have to be approved, laboratory space remodeled, and necessary equipment purchased before we could start. It's stated in the legislation that it was anticipated this could begin within three years, which would bring that date to November or December of 2010.

So that's what we're proposing in the rules, that we can start a pilot screening in November of

2010 for all five disorders, and then we would go full scale in May of 2011. And these disorders are inherited disorders in an autosomal recessive fashion, which means each parent would be a carrier so that they would not realize they're at risk for having an affected child. Treatment for them is variable. They use enzyme replacement therapy for Pompeii disease, and that's been met with fairly good success. That treatment has only been available in very recent years. Krabbe disease requires stem cell transplant. The success rates are limited, and often the children do still have some negative sequelae from the disease.

But like I had mentioned, this was initiated by families, and they felt that there were reasons to include these in the screening panel. And New York State is doing -- has been doing Krabbe, I think for three years now.

DR. KRUSE: Do you know the incidence of these diseases?

MS. NASH: There are some general statistics, and I apologize, I don't have them with me right now, but I think they're all lysosomal storage disorders, there are 40. So I think the incidence in the literature probably relate more to the combined group. We

believe that with these five, we would pick up possibly 10 to 12 or 10 to 15 children a year. Since these haven't been screened anywhere in the past, I think there is some feeling that we may not know accurate numbers because some, you know, children may have been misdiagnosed because there was no screening.

Another factor that we found when we added the disorders with tandem mass spectrometry in '02, which are amino acids, fatty acids, and organic acids, that we are also picking up through screening variant forms of those disorders. So our numbers for some of those are actually much higher than we expected, because we are picking up some benign variants.

MR. ZNANIECKI: Do you know what the false positive rate is for the population in Illinois for these tests in general?

MS. NASH: I don't think we really do for these yet, because no one has done this yet for screening. No one has done newborn screening except for the Krabbe.

DR. VEGA: You said New York did that, right.

MS. NASH: Yes.

DR. VEGA: Well, I had the same question, because if there's pretty -- in the medical world, there's

pretty -- I don't want to say standard, but there's risk/benefit analysis that's done, and if populations are moving is one issue, and then you weigh, you know, the cost benefit.

MS. NASH: Right.

DR. VEGA: So if the test is, let's say, 97 percent accurate and 3 percent, you know, so basically are you chasing your tail in something like this. But the CDC should be able -- I would think if anyone can work that out, there should be data from the CDC.

MS. NASH: I think that was one of our concerns with initiating the test is that, you know, it hasn't really been done or it hasn't been done on a -- any kind of a preliminary level. So the company -- there's a private company that actually was developing the test and had prepared the reagents for these tests called Gencom (phonetic), and they were -- they're saying that the assay is very accurate, but there has been no data published on that.

CHAIRPERSON PHELAN: Jerry?

DR. KRUSE: Me first? Well, the issue is -- well, I'll just clarify something here first. So this has already been passed, and we're just making the

rule for this?

MS. NASH: Right.

CHAIRPERSON PHELAN: Exactly.

DR. KRUSE: And my question is, is do things like this come before the State Board of Health before they're put into bills to be made into law or not?

CHAIRPERSON PHELAN: No.

DR. KRUSE: Because this is the kind of thing that this Board should actually discuss prospectively, I think. And is there a mechanism for these things to be discussed or announced at the State Board of Health before they're made into law?

MR. CARVALHO: Why don't I field that one, if I might.

CHAIRPERSON PHELAN: Thank you.

MR. CARVALHO: Sure. First off, the short answer to your question is there's not a mechanism, except for when I give a legislative report and I highlight something that you might find of interest, there's an opportunity there.

Let me tell you about this particular area. There is a legislative mechanism for adding disease screenings to the list of newborn screening. There is a committee, I forget what it's called, I just call it

the genetics committee, but it's probably metabolic or something or other.

MS. NASH: Genetic and Metabolic Diseases Advisory Committee.

MR. CARVALHO: Right. Advisory committee. And historically in Illinois, that committee has taken a lead from a national body whose name I also forget.

MS. NASH: American College of Medical Genetics.

MR. CARVALHO: Yes. Which, you know, surveys the landscape for which disorders they are going to recommend be next added. I think we are up to 20 some odd disorders now and other things that we screen for, and there is a -- the national body makes recommendations, and at least at the time that this bill was in General Assembly, we were either doing or in the process of getting ready to do everything that was on the national recommended list. Am I right so far?

MS. NASH: Yes, that's correct.

MR. CARVALHO: Okay. What happened was, a bill was introduced to add the LSD group to our newborn screening, and it's actually a theme I was going to touch on later during legislation about screening generally, not newborn screening. But in any event,

these kind of measures are very compelling to the legislature when there are people in the witness stand with children with these diseases in attendance, especially when you have a disease or a disorder for which there is or appears to be some sort of either treatment or ameliorative effort that is better to start earlier rather than later. It presents an overwhelmingly compelling case to legislators without necessarily having the same appreciation for the fine points of the statistical analysis that a medical person might look at in looking at cost benefit and medical appropriateness.

In light of that overwhelming compelling situation from the legislative perspective, what we did, which was alluded to in the discussion of this rule, was build into the legislation certain triggers that would ease our way into doing this so that it didn't inappropriately divert resources from our existing disorder screening and didn't start before -- the mandate didn't start before the equipment was in place, the reagents were vetted and the like. So all of that was agreeable to the sponsor, and so the legislation did take those realities into account.

But the bottom line in the legislative

process was this was going to happen, what accommodations did Public Health need so that it could happen on a realistic timeline. That is not an uncommon situation. It's a theme I'll touch on when I talk about legislation later, that certainly the scientific and medical perspective helps inform decision making in the General Assembly, but it does not dictate it.

CHAIRPERSON PHELAN: Thank you. Caswell?

DR. EVANS: Thank you, David. I appreciate that. I want to echo, though, the concern from a public health perspective that in terms of screening, particularly in the context that this is new, and I don't think -- I'm gathering that -- that -- that the data may be available, but the issues of specificity and sensitivity of these tests become critical, particularly in an instance where you're dealing with a rare phenomenon in the first place. And I just think from an agency perspective, you open your door to some substantial risks, as was already stated, false positives and basically false identification and insertion of treatment in effect which is both inappropriate and may in fact be damaging. And all of those risks increase with the increasing rarity of the

situation.

So from an agency perspective, I really urge you to look at the -- look at the statistical analyses of these tests and make sure you're comfortable with the sensitivity and specificity of them, because that area of analysis is always also most -- most trying with a new test.

MR. CARVALHO: Right. But I hope you appreciate what I was saying, was we are not -- we are not the policy setter in this forum. We are the policy implementer.

DR. EVANS: Yeah. My message was to the agency. As you implement it, you're embracing some risk here.

MR. CARVALHO: Yeah.

DR. VEGA: David, can we request, or at least -- and I understand, you know, the concern, but I think it's probably a good idea in the rules that we look at these numbers on an ongoing basis. So let's say -- let's say DuPage County is an area that really has a lot of diagnoses of these. At least if you have that data, you can allocate existing resources and say, you know, there hasn't been a diagnosis in southern Illinois in five years, and you may have 30 in Cook County, so you really want to make sure that at least

in certain areas that things are screened, and in other areas, you know, it may be wasteful, so at least looking forward that way.

MR. CARVALHO: Perhaps it would be a good idea. Because actually, it's interesting, I did want to touch on the issue of screening generally in other contexts, and I think your observations are very appropriate, especially in these other contexts. It might be a good refresher. As I understand it, and again correct me where I'm wrong, the newborn screening basically right now, we take a sample from every newborn in the state, and the addition of additional screens in our process is not anything that affects the collection process. It only affects the processing process down in our labs. In other words, we're not going out looking for more newborns. We're already getting all the newborns and we're already getting samples from all the newborns to run the screens. Am I correct on that?

MS. NASH: Yes, that's exactly right.

MR. CARVALHO: So this isn't like, for example, our breast and cervical cancer screening where we deploy personnel into the field through grants that we give to agencies and we target areas. Right now,

every newborn in the state is screened by drawing a sample and submitting it to our lab. The only inhibition to -- or the impediment to adding a test is having the necessary equipment and personnel to actually run the test.

MS. NASH: But the follow-up piece of the puzzle, what I think you're referring to is identifying children that may be falsely identified as positive or not identified as a negative. So I think your comments as well, but reviewing the data in the pilot period, pilot testing period would be invaluable to make sure we feel comfortable with the test.

And what everyone here discussed earlier, we did have our advisory committee, our staff reviewed all this, you know, thoroughly, and presented it to the public health subcommittee in the Senate, and the advisory committee as well, did voice these same concerns.

CHAIRPERSON PHELAN: Jerry?

DR. KRUSE: I'll just go back to what I said before. All of these things point to the fact that the State Board of Health should have some voice in this process before, and we ought to raise the awareness of where we can insert ourselves into this

process. I don't know if there's some policy that needs to be made about this, but carefully examining the risk/benefit ratio and the potential harms of a test is very appropriate for a State Board of Health, and I feel that it's very important to do that in addition to making the rules for implementation.

CHAIRPERSON PHELAN: David?

MR. CARVALHO: My own estimation, and I don't mean to -- don't take anything wrong by this, if a legislature isn't going to listen to the Department of Health or to NIH or CDC or any of the other organizations they currently don't listen to, you may just be adding yourself to one more list of things that they don't listen to.

DR. KRUSE: That's possible.

MR. CARVALHO: I mean, I guess that's pretty frank. But be that as it may, I appreciate the offer to add your weight to these discussions, because it does get sometimes -- it's always good to have additional voices.

DR. JACKMAN: David, was any additional funding given for this new testing?

MR. CARVALHO: It was one of the things that was built into the law as one of the triggers, was that we

had time to adopt an increase in the fee so that we could recover the costs.

DR. JACKMAN: Okay.

MR. CARVALHO: Because, yeah we said, you know, you can't keep adding tests and not pay for them. No, we -- it's a couple of years ago, and I may be forgetting the details, unfortunately. We had just increased the fee prior to that for the most recent tests we had added, if I remember right, cystic fibrosis.

MS. NASH: That's correct.

MR. CARVALHO: And so the hospital association was -- was leery of us increasing the fee again, because I guess although the fee is charged to the patient, the hospital association is not a hundred percent successful in collecting those, and so -- so they have an interest in keeping those fees down.

MS. O'SULLIVAN: The fee went up from 59 to $78, I see here.

MR. CARVALHO: Yeah.

CHAIRPERSON PHELAN: Okay. Thank you, Claudia.

MS. NASH: Thank you.

CHAIRPERSON PHELAN: Okay. Just to clarify, Jerry, which continues on with what we were talking

about. The rules committee, when we meet, we basically dissect the rules and we question everything and we request further clarification, and then we make changes and adjustments. And if it passes by the legal department, they concur, then what you receive in your packet is the revisions from our meetings. So based on the summary of our meeting that David McCurdy prepared, I went ahead and made sure that the changes were made. And the first thing you will note is the definition of LSD on Page 3 that was extended to provide additional clarification.

And then also on Page 4, the top of the paragraph, it was changed. I believe it was at David -- at Caswell Evans' suggestion that it be changed from false positive and false negative results, you will see that's underscored there. And then finally we made some grammatical changes on Page 8. So does anyone have any other changes or questions?

DR. KRUSE: I have a few. On Page 12, one of the categories listed is sickle cell disease/trait. Quite frankly, there is no need for a pediatric hematologist oncologist to see someone with sickle cell trait at all, and I would recommend the trait be taken out.

CHAIRPERSON PHELAN: Okay.

MS. NASH: Yes, because that category does discuss diagnosis and treatment, so you're correct.

DR. KRUSE: In a lot of places on Page 9 and following, there is language that the medical specialist or the pediatric endocrinologist to whom the patient is referred have at least one year of training -- at least one year of practice after their training is completed before they get referred patients in this program. I would just say that pediatric endocrinologists are not in overabundance in many parts of the state of Illinois, and I could see no reason to exclude anyone who had completed their training from seeing these patients. I don't understand the reason for the one-year waiting period for a specialist to be on the state's --

DR. VEGA: I didn't catch that. I don't understand that.

CHAIRPERSON PHELAN: Can you be specific on where on Page 9?

MS. O'SULLIVAN: Page 9, up on No. 3.

DR. KRUSE: It's in many of these, 3, 4 and 5, they say they need to be in practice for at least one year, or at least one year experience post training.

MS. NASH: That is historical, is all I can say. That's historically, I think, been in these rules. So I agree with you. If they're trained in a subspecialty area, I would assume they would have adequate experience caring for these children, so.

CHAIRPERSON PHELAN: So we can make that adjustment, Claudia?

MS. NASH: As far as I'm concerned.

DR. VEGA: To the whole document?

CHAIRPERSON PHELAN: Jerry?

DR. KRUSE: I have one more. The other one relates to what we spoke about before. There's fairly abundant literature on some of the harm that can be caused by screening for conditions that are of very low incidence and have a fairly significant false positive rate. Some of the writing has been done about a case called the Baby Jeff case, and I would just say that when you -- we make the recommendations for referrals for evaluation by pediatric endocrinologists and medical specialists, that there ought to be some language there that keeps the primary care and physician involved as well as part of that team that's dealing with these tests. Because that's what was brought out of the Baby Jeff case, as an

example, but that was my only other thought.

CHAIRPERSON PHELAN: Okay. And is that appropriate, Claudia?

MS. NASH: Yes, very much so. Would you suggest that we insert that language in the Section 66135A, perhaps?

MS. O'SULLIVAN: What page is that on?

MS. NASH: That's on my Page 8.

DR. KRUSE: Rather than putting it under every category, some general statement to that effect might cover the whole thing.

MS. O'SULLIVAN: Uh-huh.

MS. NASH: Yeah.

CHAIRPERSON PHELAN: Any other questions, concerns, suggestions? Then based on the additions that we made, I move that the Board forward this to JCAR for recommendation for approval.

MS. O'SULLIVAN: Second.

CHAIRPERSON PHELAN: All in agreement?

VARIOUS: Aye.

CHAIRPERSON PHELAN: Okay. Moving on, then, to Heartsaver AED Grant Code. Thank you, Claudia. I'm sorry.

MS. ATTEBERRY: Paula Atteberry, Illinois

Department of Public Health, Office of Preparedness and Response, special programs coordinator.

DR. ORRIS: I'm sorry, did you take a vote on the first one?

CHAIRPERSON PHELAN: Yes, we did.

DR. ORRIS: I hadn't checked in. I've been on the phone for a while. This is Peter Orris.

CHAIRPERSON PHELAN: Sorry, Peter. Hello. Do you agree?

MR. HUTCHISON: He said aye.

CHAIRPERSON PHELAN: He did? Okay.

MS. ATTEBERRY: The Heartsaver AED grant law was revised to expand the eligibility for the grant program to include private schools, colleges, universities, forest preserve districts, conservation districts and municipal recreation departments. That was one of the changes.

The second change in the law that was amended was that legislation also would eliminate the requirement that the Heartsaver grant would go to physical fitness facilities people who qualify -- who had to have AEDs. Those are the only two changes.

CHAIRPERSON PHELAN: Okay.

MS. ATTEBERRY: And so that's why we made the

amendments in the administrative codes. Do you have any questions?

CHAIRPERSON PHELAN: Any questions, concerns from the Board?

MR. HUTCHISON: It's not a question about the proposed rules per se, but was there a fiscal note or was there any changes in the funding or the grant funds that are being made available, since we're expanding or propose to expand the eligibility of applicants?

MS. ATTEBERRY: No. In fact, fiscal year 2009 was not funded.

MR. HUTCHISON: Well, I think it's notable that the proposed rules -- I certainly would speak in favor of moving the rule along as was proposed in the Act, but with the caveat or the note that, you know, a good policy, without the resources to implement that policy, leaves a short of protecting the health as we would like to do.

CHAIRPERSON PHELAN: So noted.

MR. CARVALHO: This is Dave. Again, sort of a general theme. As you may know and heard me say in the past, lots and lots of bills get introduced in Springfield, especially on the issue of health.

Health is a very popular topic to legislate upon, and oftentimes the -- if the reason -- among the reasons that we're opposed to a bill is there's nothing -- there's no provision for paying for it, rather than the legislative sponsor therefore withdrawing their bill, they nonetheless seek the adoption of their bill with a provision that says subject to appropriation. And if there is no appropriation, as often there is not, then the bill is on the books and apparently the law, but it has that caveat, subject to appropriation. Nonetheless, the bill is on the books, and so we are obligated, maybe not with the same alacrity as in other cases, but obligated to push through the process of adopting rules. So you will increasingly see rules coming to you that are implementing bills that actually do not have funding, but we have been chastised by the legislature for not having rules to support every piece of legislation they adopt. So we have to go through that exercise.

MS. O'SULLIVAN: And for clarification, David, are you then also required to implement the bill even though there's no funding?

MR. CARVALHO: Not the ones that say subject to appropriation.

MS. O'SULLIVAN: Okay. Good.

MR. CARVALHO: That's -- otherwise we would be in an impossible situation.

MS. O'SULLIVAN: Right.

MR. CARVALHO: Now we're just in a futile one.

DR. VEGA: Question.

CHAIRPERSON PHELAN: Tim.

DR. VEGA: And speaking about conservation districts, is that like for people who would patrol those areas?

MS. ATTEBERRY: Correct, for any first responders that works in the conservation district.

DR. WHITELEY: David, how much time is required to implement or develop rules where you're not going to implement them?

MR. CARVALHO: It varies. Some rules are pretty straightforward, just require a moderate amount of a person's time. I've worked on some rules that have involved, you know, an extensive amount of time. Fortunately, most of the rules that I've worked on that have involved an extensive amount of time have been ones that are also real programs, and part of that is just, you know, prioritization on our part. If you can't do everything, you do, A, first the

things that are actually funded, and then B, the things that are perhaps easier. And if there are really hard things that are bills that actually have no funding and no prospects of funding, you know, in a world of limited resources, those get lowest priority to get completed.

DR. WHITELEY: Thank you. I was just hoping you were prioritizing.

MR. CARVALHO: Yes.

CHAIRPERSON PHELAN: Thank you, David. Any other questions?

DR. EVANS: Yes. David, I just had a purely procedural question. Does the State anywhere maintain a database that would reflect to what degree or frequency these types of interventions are activated around the state?

MR. CARVALHO: I do not know. Does the -- who is here for the program?

MS. ATTEBERRY: I'm sorry. What was the question?

DR. EVANS: Is there a database that would reflect how many times these types of interventions are actually implemented? Do we even know how many defibrillators there are out in these kind of public

places and how often they are implemented? I'm just curious.

MS. ATTEBERRY: There is a database that Dan Lee (phonetic) is developing. We use the bubble sheets for EMS. And the database will capture all AED uses and the outcomes of those uses.

DR. EVANS: Okay.

MS. ATTEBERRY: So that is really close to being there, so that we'll get a lot of information from that.

DR. EVANS: Yeah, because that at least will --

MS. ATTEBERRY: Right now you would have to go to every hospital, but this will bring it all together.

MR. CARVALHO: Will it only bring together ones that are used in a hospital, or all the different settings where we have them in place?

MS. ATTEBERRY: It would bring in the prehospital, the AEDs that are used prehospital. Because most hospitals use AEDs on the floor for very brief -- until the code team comes. So they don't -- I don't know that they really keep information, other than prehospital AED information.

MR. CARVALHO: So AED use that leads -- results in a hospitalization will be captured; AED use that

doesn't won't?

MS. ATTEBERRY: Right.

DR. EVANS: I mean, obviously I'm just pointing out the obvious, but it gives you some crude measure, at least, of effectiveness and utility.

MS. ATTEBERRY: Sure. That's what we're hoping.

DR. EVANS: Yeah.

CHAIRPERSON PHELAN: Kevin?

MR. HUTCHISON: Just to answer that question, our department coordinates our AED program for our county, and it's my understanding of the law, when there is an AED device utilized, there is a reporting form for each act, either by the civilian or public employee responder or the EMS personnel. So there is data being collected on the utilization of each AED when -- every time it's being used, regardless of whether that results in a hospitalization or not, is my understanding. So I think Doctor Evans' question is well placed. I think the data is being generated, and when there is this data set -- you know, statewide database developed and utilized, I think the raw data is being pushed out. And it's part of my understanding of the original law that when the AE device -- when that button is pushed, that has to be

reported to the regional EMS facility.

MS. ATTEBERRY: It is. You just would have to go several places to get it, where this will bring it to us.

CHAIRPERSON PHELAN: Okay.

MR. CARVALHO: So to clarify, then, it's required to be reported someplace, but right now it's not required to be reported to us?

MS. ATTEBERRY: We could gather that information. But, no, they don't send -- the resource hospital used to send us quarterly updates, and that was changed by law so they do not have to do that anymore. But that doesn't say that if we want to go look, we could.

CHAIRPERSON PHELAN: Okay.

MS. ATTEBERRY: Does that make sense?

CHAIRPERSON PHELAN: Yes. Any other questions? Peter?

DR. ORRIS: I'm sorry?

CHAIRPERSON PHELAN: Any questions?

UNIDENTIFIED SPEAKER: Any questions, Dr. Orris?

DR. ORRIS: No, we discussed this in committee. No.

CHAIRPERSON PHELAN: Anyone else on the line? Then I suggest we move that the Board forward this to

JCAR for recommendation for approval.

MS. O'SULLIVAN: Second.

CHAIRPERSON PHELAN: All in favor say aye.

VARIOUS: Aye.

CHAIRPERSON PHELAN: Thank you, Paula.

MS. ATTEBERRY: Thank you very much.

CHAIRPERSON PHELAN: Moving on, then, to our final rule, which is Home Health, Home Services and Home Nursing Agency Code. Who will be providing information on that?

MR. BELL: I can do that.

CHAIRPERSON PHELAN: Okay.

MR. BELL: I'm Bill Bell, and I'm with the Office of Health Care Regulation.

These rules have already gone through the Home Health Advisory Board. There is a little glitch in the law that doesn't allow -- well, there needs to be some statutory language that says that the advisory board has a certain number of days to act on a rule before it becomes null and void. That language is missing from the Home Health Advisory Board, so that's why this rule has to come in front of the State Board of Health, because every rule has to be reviewed under a certain procedure. So that's why this is back in

front of you.

Last year we implemented the original set of rules. There was a law passed that effective September 1st, 2008, there was a new licensure category for home services and home nursing. In the past, the only entity that was regulated was home health. And basically, these are the steps below home health, where you have actual nurses going into a persons' homes providing care. And the other service is home services, where it is people going in providing assistance with activities of daily living, shopping, laundry, those types of activities, and in the past those were not regulated. The legislature decided that that was an area of possible abuse, so they set up a licensure category for those new services, and we adopted the rules, and we are in the process of licensing entities now.

The rules that you see in front of you are basically some cleanup language that once we started to put out the applications, and since these again are new providers, they came back with some questions and some issues that were not addressed in the original set of rules, because we hadn't gone through the application process yet. So what these rules are,

basically, again is just to clean up some of the concerns that some of the industry members had, and in some cases, what the Department had in certain areas. So with that brief explanation, I'll be happy to answer any questions if you have any on these amendments.

CHAIRPERSON PHELAN: Anyone? Ann?

MS. O'SULLIVAN: I would just comment on your addition on Page 5 down at the bottom there, that I appreciate your clarifying that all the services are provided under the direction of a registered professional nurse. I would also like to say that I see later on you define licensed practical nurse. Actually, anything that a licensed practical nurse provides also must be under the direction of a registered professional nurse, according to the Nurse Practice Act. So you have said in here everything has to be congruent with the Nurse Practice Act. Those are areas very poorly understood by both health aides and licensed practical nurses.

So I just wonder if under where you say licensed practical nurse on the bottom of Page 6, you define who it is, but I wonder similar to what you did on Page 5 or somehow there that you add the LPNs are

also practicing -- well, not practicing under, but their services are provided under the direction of a registered practical -- a registered professional nurse.

MR. BELL: Okay.

MS. O'SULLIVAN: Maybe it better fits on Page 5, home health aide nurses and licensed practical nurses, or something like that, but they also have to be delegated by an RN.

CHAIRPERSON PHELAN: Yes.

DR. KRUSE: Could an LPN be a director of a home health agency?

MS. O'SULLIVAN: No.

DR. KRUSE: No? Even if someone else supervises --

MS. O'SULLIVAN: And it even says it up above, no, they can't.

DR. KRUSE: And was physician removed from Page 14 just because no physicians do this?

MR. BELL: What was --

CHAIRPERSON PHELAN: 14E?

MR. DAILEY: My name is Sean Dailey, S-E-A-N, D-A-I-L-E-Y. I think that came up in the rules committee meeting. And if I recall, it is just not

done at -- nurses and physicians are both licensed, and there's some sort of protocol where one is not under the direction of another as far as a supervisory position goes. That's -- and that's why we took that out.

UNIDENTIFIED SPEAKER: I don't know about anybody else, but whoever is speaking can't be heard over the phone.

MR. DAILEY: I'm sorry. My name is Sean Dailey. I'm with the Office of Health Care Regulation. The question was why physician was struck on Page 14 of the rule under agency supervision for home health agencies. And to the best of my recollection, that was struck because a -- speaking of both -- of two different coins of licensed individuals, nurses and physicians, and as far as the supervisory role in an institution like a home health agency, you can't have a physician over a nurse in a supervisory role dealing with an administrating agency, not as far as I think health care is concerned. I can check --

MS. O'SULLIVAN: That doesn't make sense to me. I'm not sure if it's in the law or not, but that doesn't make sense to me.

DR. KRUSE: No, there are plenty of physicians

who supervise care in offices, and there may be some physicians who are supervisors in home health agencies. I don't know the answer to that question. I guess one of the concerns would be if there are, this might cause a problem if it was changed for the people who are supervisors now.

MR. CARVALHO: Sean, where did the issue come up?

MR. DAILEY: I think it was in the rules committee meeting a couple of weeks ago.

MR. CARVALHO: So you responded to some --

CHAIRPERSON PHELAN: I don't know that to be true.

MS. MEISTER: I think that change was in there already. Do you remember, Bill?

MR. BELL: You don't have a list of the second notice comments or where that came up?

CHAIRPERSON PHELAN: It was removed. When it was presented to us, it had already been removed.

MR. DAILEY: That's correct. It was already struck at the rules committee.

CHAIRPERSON PHELAN: Before --

MR. CARVALHO: So where did the comment come from, Bill -- Sean?

MR. DAILEY: My memory is not clear. I would

have to check up on that. I can go and ask the staff who advised us to do that and come back.

MS. MEISTER: Our nurse isn't here today, and she was the person who would be able to respond to that question.

CHAIRPERSON PHELAN: Ann?

MS. O'SULLIVAN: My concern is that it doesn't make sense. If physician is put back in, it seems to me they ought to have similar kind of experience as nurses do, as nurses are required here under the new B, some type of community health home care experience. I mean, if it's put back in, they ought to have some of that experience also. Under the nurses who have already have a Bachelor's Degree, that's not there because they get that in their schooling. I would imagine most physicians don't get home health care routinely.

DR. KRUSE: Well, it's a requirement in family medicine residency training programs, that home visits are done.

MS. O'SULLIVAN: Okay.

DR. KRUSE: It's not extensive, but it's a definite requirement for certification.

DR. VEGA: That can be inserted, that if --

experience can be a part of the residency training program.

DR. KRUSE: Demonstrate training and experience.

DR. VEGA: I just think it should be reinserted. I'm not sure --

CHAIRPERSON PHELAN: In the same location?

DR. VEGA: Yeah, and I just don't understand that. There are areas where -- I know programs where nursing run the programs. They're excellent programs, they run quality programs, but I know others where there are physician supervision. So striking this may put maybe two places I know out of business. So I just --

MS. O'SULLIVAN: Physicians certainly supervise nurses or direct nurses in terms of health care. I understand that the issue is supervising or directing in terms of managing the services. I understand that there's a difference there. I'm not -- I don't ever remember reading anything in our practice act, anyway, about that not being allowed.

MR. BELL: Let me try to explain. Just talked to my nurse over there. Basically you've got two positions. You've got the home health agency administrator and the home health agency supervisor.

We struck physician for the supervisor, because if you have a physician as the administrator and you put in another physician as the supervisor, then you don't have anyone -- you don't have nurses who can control the other nurses.

MS. O'SULLIVAN: Who can direct and delegate to the other nurses?

MR. BELL: Exactly.

MS. O'SULLIVAN: I get you. Where does it say here that physicians can be administrators, then? Back on an earlier page? That does make sense.

DR. KRUSE: If we're separating administration from direct supervision --

MS. O'SULLIVAN: Yeah.

DR. VEGA: We should clarify that. If we're talking about a nursing supervisory role for nursing --

MS. O'SULLIVAN: Nursing care.

DR. VEGA: -- care, I think that makes sense. So clarification, I think.

MR. BELL: Okay. We can clarify that. But that's the purpose, if you have two physicians, then you would have nobody that could control them.

MS. O'SULLIVAN: Got you, control being used in a

very general sense.

MR. HUTCHISON: Just one addition. Along this thought, and I guess I would defer to maybe Ann or someone in the room, but our earlier discussion, we talked about an LPN working under the direction of a registered professional nurse. But as I recall the Nursing Practice Act, an LPN can also work under the direction of a licensed physician.

MS. O'SULLIVAN: So can an RN.

MR. HUTCHISON: So can an RN. So if that's true, it would seem that a physician, if they're not the nursing agency administrator, could supervise the nurses. I mean, I guess it just adds to it -- I think we need to have clarification here, because in other parts of the law, licensed physicians can directly supervise nurses, registered professional nurse and/or LPNs.

MS. O'SULLIVAN: They can delegate to both of those groups.

MR. HUTCHISON: I don't think we want to set a rule which would preclude what's legal in other practices of medicine to the home health agency situation.

MS. O'SULLIVAN: But the issue to me would be

from a practical and a professional standpoint, the nursing care ought to be directed and delegated by a registered professional nurse, because the physician would be doing the same with the medical care or the administration of the -- but it is legal, I mean, in the Practice Act they can be delegated by any of those.

MR. HUTCHISON: Right. I agree.

MS. O'SULLIVAN: So I think it's preferential the way this is worded, now that we understand what it means.

CHAIRPERSON PHELAN: So do we need to make further clarification or --

MS. O'SULLIVAN: Where does it say the administrator? I flipped through. I just wanted to see what the difference is there.

MR. BELL: I don't know if we got that in --

CHAIRPERSON PHELAN: I don't think we do.

MR. BELL: We only showed you the sections that have changes to them, so I'm not sure if the administrator -- let's see. We've got the --

MS. O'SULLIVAN: Oh, it says on Page 5 under the definitions, the administrator can be any one of the following.

DR. KRUSE: Yeah, there it is.

MS. O'SULLIVAN: And then someplace else it must define that similarly to the supervisor, I would imagine.

DR. VEGA: I think I kind of have either/or. And you know, if there are -- if there are quality -- I don't want to say quality, but if there are regulations looking at brainpower or experience in there, I would think if you had someone who is functioning from physician to staff one way, and you had another situation where registered nurses were involved in the care, I think you would obviously think that that team would be a better source of care. Each of them brings something to the table. But I really think you shouldn't exclude one way or the other, here should be one or the other, and if you want to express a preference or if it's in the rules, if you have some nursing personnel that brings a measure of quality to the team, well, then fine. I think that makes sense.

CHAIRPERSON PHELAN: Okay. Any other questions? Concerns? Then I suggest that we move to send this to JCAR for recommendation.

MS. O'SULLIVAN: Second.

CHAIRPERSON PHELAN: All in favor?

VARIOUS: Aye.

CHAIRPERSON PHELAN: Thank you, Peter. Thank you very much, Bill.

MR. BELL: Thank you.

CHAIRPERSON PHELAN: Okay. All done with the rules committee. Thank you to everyone who helped us, Susan and her team. Susan's pretty tough on us, just so you know. I go on the record saying that Susan.

Okay. Next in, policy committee report.

MR. CARVALHO: Chairman Phelan?

CHAIRPERSON PHELAN: Yes.

MR. CARVALHO: Can I again thank you for your diligent work on these rules. Every rule today got improved by comments from the Board, so thank you.

CHAIRPERSON PHELAN: Thank you.

MS. O'SULLIVAN: The Policy Committee met by conference call on February 5th, and the majority of our discussions surrounded the State Health Improvement Plan, the SHIP overview. Is Jim or Elissa on the phone?

MR. HARVEY: We're both here, Ann.

MS. O'SULLIVAN: Wonderful. If you would like to report additionally on the assessment update that

we'll be having on March 23rd, I think that would be great.

MR. HARVEY: Certainly. Just to give you an update on that, as we reported to you, we continue to stay on the timeline for SHIP with the assessment, and by now you should all know about the update and retreat that IDPH and IPH are going to be doing on the 23rd. It is a multi -- we'll be bringing together multi sector stakeholders to participate in the assessment for a full day facilitated retreat that will be convened by IDPH and the State Board of Health. The findings of the assessments will be collated and reported to the State Board of Health hopefully by sometime in April, the following month.

Registration for the assessment retreat extends to local health departments, key state agencies and multi sector stakeholders from across the state. As of today, we're pleased we can report that 62 people have in fact already registered for the retreat, and we've encouraged all participants to ahead of the retreat complete a one-hour recorded webinar that we prepared, which is jointly presented by the Illinois Department Public Health Institute, APSO (phonetic) and CDC.

In addition to that, we continue to work on refocusing our assessment work and concentrating now on health status assessment and community teams and the strength assessment, and looking at that and revisiting all those issues and those topics. We're going to revisit the I-plan priorities and look at other state plans that have been developed since we last visited these areas, and we're continuing to develop materials in anticipation of the SHIP team being appointed so that we can again begin to move ahead in a rapid pace with working into the next SHIP.

That is where we are in terms of SHIP work and the assessment. I can also give you the legislative update, if you would like.

MS. O'SULLIVAN: Great.

MR. HARVEY: We're working with the Governor's office and with IDPH on the content of House Bill 3767, which is titled The Obesity Prevention Initiative, which passed out of the Human Services Committee on Wednesday. We are also exploring the development of a Center For Health Disparities and Health Equities, and we are working with the hospital association and Northwestern University on legislative initiatives that will hopefully lead to the

establishment or support of a center for workforce development. Just as a reminder, these are three items that resulted from priority recommendations at the last SHIP summit.

MS. O'SULLIVAN: Any questions?

MR. HARVEY: And that's where we are.

MS. O'SULLIVAN: Two questions I have. Have the announcements gone out of the webinar being ready, or are we supposed to get that -- how are we supposed to get that?

MR. HARVEY: Yes, those announcements I believe have gone on.

MS. BASLER: This is Elissa. The webinar is going to be posted today on the I-plan website, and an e-mail will go out as soon as it's posted to all of the registered participants.

MR. HARVEY: I knew that.

MS. O'SULLIVAN: Great. And David, where are we with appointments to the SHIP team? Do we expect those to come sooner than we might have previously?

MR. CARVALHO: Yes. Without going into the gory details, as you might imagine, since the process for appointments of all -- all bodies such as this under the prior Governor's administration were required to

be submitted to the Governor's office, there was some -- the process has been bumpy. But we're adjusting to the -- we're adjusting to the new process, and I think we should have something soon.

MS. O'SULLIVAN: Okay, great. I just felt obligated to ask.

MR. CARVALHO: I'm always mindful of the fact that there's a court reporter in the room.

MS. O'SULLIVAN: You do very well. She doesn't record our nonverbals either.

CHAIRPERSON PHELAN: As we roll our eyes.

MS. O'SULLIVAN: Right. Elissa, do you have anything you want to add on the whole SHIP process or the timeline or anything?

MS. BASLER: No, not unless we -- anybody has any questions that we can answer.

DR. EVANS: Elissa, it's Caswell Evans, hi. I was looking at some of the Stimulus and Recovery Act solicitations, and I'm sure you're following that. There are several opportunities for health disparities, work-related projects that could be supported, but I assume you're all over that. But I just wanted to --

MS. BASLER: Are these solicitations that are --

no, if they're going out to -- I'm only aware of money that's running through the state. If there's money that's --

DR. EVANS: Check out the HRSA website --

MS. BASLER: Okay.

DR. EVANS: -- and you might even look at the NIH website. But those are all research related, but that doesn't mean you couldn't put a research tail on some of the things you're doing.

MS. BASLER: Oh, yeah.

DR. EVANS: But there's funding there, both in HRSA and in NIH.

MS. BASLER: All right.

DR. EVANS: Yeah.

MS. BASLER: We'll look for that.

CHAIRPERSON PHELAN: Kevin?

MR. HUTCHISON: This is just related to the Policy Committee and following up on Dr. Kruse's comments earlier relative to when legislation or things are introduced, how can we as a State Board of Health be involved upstream. And this, I guess, is a question for -- or request to you, David, and Dr. Arnold. Is there or can we explore ways where -- wherein the various departments of the Illinois

Department of Public Health who are involved in legislation review and legislative analysis and impact analysis, as they do their work share that; at least that there's been bills introduced or some notification to members of the State Board of Health who then at large could, you know, be aware of these issues, and in certain of those may want to be followed up, you know, through our Policy Committee.

I think there is a great deal of work and effort and analysis that is being done by staff with the state health department, and if that information as it's being developed could be shared with members of the state board, it may be very helpful in improving awareness upstream so that we know the history and the context of rules that subsequently get bundled down and put before this body. I am very aware that much of the legislation happens very quickly, and sometimes this would not be practical or possible, but when practical, when possible, I think there's -- with electronic communications, it just seems like there may be an avenue for the analysis that staff are doing on proposed legislation by the state health department at least could be shared with State Board of Health members.

MR. CARVALHO: Okay. Well, why don't I address that in my legislative update, which is the very next item once you wrap up on SHIP, and we can go ahead into that.

MS. O'SULLIVAN: I have two other comments from the Policy Committee. Right after our last full state board meeting in December, Dr. Vega put together with Dr. Orgain an application for the CMS application, and I just wondered if we knew anything about that. I'm sure we would have been cheering if we got money yet, but --

DR. VEGA: Right. The CMS is ready to go and pick the states; however, they need a green light, a last checkoff from the Office of Management and Budget before they announce, and it should be within a week.

MS. O'SULLIVAN: Excellent. Great job, Tim. Thank you.

CHAIRPERSON PHELAN: Thank you, Tim.

MS. O'SULLIVAN: We'll just keep our fingers crossed.

And lastly from the Policy Committee standpoint with our original agenda, which of course a large part of it was the SHIP, we also had on there patient safety, and I wondered, David, if we could get

an update either from you now or in another meeting on the Center for Patient Safety and what the initiatives are and, you know, what is all going on with that.

MR. CARVALHO: Sure. Let me give you a brief one now, and at your next Policy Committee I can ask Mary Driscoll, who heads up that center, to also participate. In fact, one of the things that I was waiting to note was that on the SHIP -- well, I mean, obviously I will continue to be as involved as I have been. I've also asked Mary to directly get involved --

MS. O'SULLIVAN: Great.

MR. CARVALHO: -- in particular in coordinating with IPHI, the activities of the health department and IPHI in support of the SHIP. So you will -- some of you already know Mary Driscoll, but more of you will become familiar with her. She was a former colleague of Peter Orris's over at -- where both of them used to be, Cook County Hospital, Stroger Hospital, and she's been the director of the division of patients -- chief of the division of patient safety for the last year and a half.

The principal charge of the division of patient safety initially was, and it's still working

on that initial charge, which is to discharge some of the existing obligations of the Department with respect to Hospital Report Card Act, the Consumer Guide to Health and the adverse health care event reporting law. And the challenge that Mary has had is that same expression I used earlier, that the process for hiring people into that division to assist her had multiple pass through the Governor's office of management budget and CMS, and in fact those processes were not functioning smoothly, so Mary continues to operate without staff and doing a yeoman's job.

We have gotten the adverse health care event reporting law rule, moved that forward. It's not yet final. The rules to support the Consumer Guide to Health and the Hospital Report Card Act are final. There our impediment has been we do not -- did not have the resources internally to develop the website and the data processing for the Hospital Report Card Act, so we developed and issued an RFP to secure a vendor, and the process for approving contracts over the last six to nine months has also had some pickups. And we identified a vendor in early November as the result of the RFP process, and have been awaiting since November the approval from CMS to move forward

with the contract.

Quite understandably, when the new Governor came in, all contracting was kicked back one step for revetting, and so that particular contract is currently being vetted once again, and once the vendor -- once we are permitted to contract with the vendor, we anticipate it will be four months or so before the website is up with the data.

You know, quite frankly, the ability of Mary to turn her attention to issues of more generic -- related to patient safety is slowed by her lack of staff. She has contracting -- contracted with staff, which has allowed her to be involved in some electronic prescribing initiative with Blue Cross. We are working with HFS on some electronic health record initiatives, and Mary continues to be out there as an evangelist on the topic of patient safety, but clearly we will be able to move more forward in a more robust way when some of the staff have been hired for that division. As I say, and maybe there's not a formal report to give, but I'll ask Mary to participate in the next Policy Committee meeting to give a report.

MS. O'SULLIVAN: Good. I just think that we need to keep that on our plate as a Policy Committee

reporting to the Board here, because it feels like although she's doing a great job and you've got great initiatives, we're not really moving ahead in statewide patient safety planning.

And Elissa, I was going to mention from the Policy Committee an idea that I had that I was going to bring up at our next meeting. But if you're looking at some grant money, the whole concept of a just culture in terms of medical errors, mistakes, et cetera, et cetera, is something that's really starting to go countrywide, and I know that we're looking at it within the nursing association and trying to work potentially with hospitals and the boards of nursing in the various different states.

And it's the concept of not exactly blame free, because there are some times where people do things wrong, but pretty much punishment free and education oriented and things like that. So I think that might be something that we could look at through the state, and it certainly comes under the patient safety initiatives in how we provide that. So I don't know, Elissa, if that's something that's listed in where Caswell said all the money was, but we could certainly investigate.

MS. BASLER: I'm trying to find all that money while we talk, but I'll let you know when I get the check written by the end of this meeting.

MS. O'SULLIVAN: All right.

CHAIRPERSON PHELAN: Kevin?

MR. HUTCHISON: I have one other comment maybe for you, David, on patient safety. It's my recollection and understanding that the federal stimulus had quite a large sum of resources directed to patient safety, at least hospital acquired infections and so forth. And maybe we'll be anxious to learn what portion of that will come to Illinois and how that will be operationalized, if that's coming through the state health department or directly to hospitals.

But there are -- is -- it's been nationally recognized and, of course, we know here in Illinois with methicillin resistant staph aureus and other infections, it's a big deal. That might be something we might like to learn more about how Illinois will be -- what federal dollars may be coming and how Illinois plans to use it, specifically related to the -- our patient safety issues.

MR. CARVALHO: As luck would have it, that was

going to be on my legislative update as well, because I'm the point person for the federal stimulus for the Department.

CHAIRPERSON PHELAN: Doesn't surprise us.

MR. CARVALHO: You want me to move to that now?

CHAIRPERSON PHELAN: Are you finished?

MS. O'SULLIVAN: I'm finished.

CHAIRPERSON PHELAN: Yes, please. Thank you.

MR. CARVALHO: One of the other noteworthy events that's occurred since the last Board meeting of the State Board of Health, of course, was the inauguration of the new president and the option of the stimulus bill. And the -- those of you who followed this closely know that it's -- you know, it was up the hill and down the hill a little bit with respect to public health and the stimulus bill. As the bills wended their way through the two chambers, each chamber had some really great provisions, and as they came together in conference committee, many of the really great provisions dropped off, leaving what's behind looking small by comparison, but huge by comparison to what existed beforehand.

So on the one hand, it's a little bittersweet to look at the bill and think what might

have been if the best provisions of the House and best provisions of the Senate with respect to dollars for prevention and the like had remained. As Kevin alluded, a significant amount of money nonetheless survived.

It's a little frustrating, and it certainly has been frustrating to the folks in the Governor's office who want to put this all on the web under recovery.Illinois.gov, but in the health area, there was less denomination of exactly what money was going to go exactly to whom in a recipient state exactly for what. So almost immediately, state departments of transportation across the country could say, you know, we're getting 23 -- $234.7 million for the following projects and the following regions, but with respect to health, the provisions were a little more obscure in that they -- the money was allocated to a federal agency, which then had to determine how they were going to later distribute it.

But by far the biggest dollar amount, of course, is the money for health IT, and in particular on payor side, Medicare and Medicaid, the incentives in the bill to encourage the adoption of electronic health records by providers. I believe the scoring

for that was something like $17 billion, but I think that's a net score. There's actually more dollars than that that will physically go out the door to providers, but there is also an assumption that there will be savings attributable to the adoption of electronic health records, and so for purposes of scoring, which is what they do in Congress when they try to figure out how much a bill is going to cost, the number they came up was a net number of about $17 billion.

There was also $2 billion set aside for purposes of grants to the states to plan for the adoption of health -- electronic health records and the development of health information exchange. There was money set aside for the encouragement of health information exchange at the regional level, and there was money set aside for grants to states to set up revolving loan programs which need money to fuel their initial loans, also for the encouragement of the development of a robust electronic health record and health information exchange.

We are monitoring what timelines and parameters the federal agencies will put on the distribution of those funds. There are not any funds

in that category, you know, that start off with the Illinois' name on them. Some of the funds will probably be distributed pursuant to application. Some of the funds will be distributed pursuant to competitive grants.

There's also a $1 million slog of money set aside for prevention and wellness activities, again, to the -- divided up in various ways among programs and federal agencies, and we are working to understand how the federal agencies are going to turn around and distribute those. As Kevin said, there's a slog of money set aside for state efforts to control health -- hospital acquired infections, HIEs. There is funds set aside for vaccines, and that one we have received the most information on.

The intent is to -- at least part of the funds is to increase the product that is distributed in kind to the states, and so our immunization office, under Karen McMahon, has been participating in a lot of phone calls over the last several weeks with CDC on what's going to go where, when, and then we're going to, you know, redistribute that information to the local health departments and others as we get it.

There are funds to benefit community health

centers that, as near as we can tell, are going to be distributed directly by HRSA. They will not flow through the state agency. Some of those funds have already been announced. HRSA a couple days ago announced some grants based on, if I read it correctly, last year's determination of need that was unfunded with these funds, HRSA will fund it. And there were four grants of $1.3 million distributed to four FQHCs, one at Lake County Health Department, Lawndale Christian, one -- I forget, Carbondale or Collinsville, and then another one in Chicago.

But the balance of that one -- HRSA has got, I think, 1 billion in one category and half a billion in another category for distribution, and we don't believe that's going to go through the states.

I think I'm forgetting some categories. I didn't bring my distribution list memo with me. But we are monitoring those, and we are receiving much more in the way of inquiries from people who want to get the money from us, assuming we're going to get it, than we are getting information from the feds on what money we are going to get. And that probably doesn't surprise anybody. I'm getting a lot of cold calls from health information companies.

And by the way, as you may recall from prior discussions, the health information exchange activity at the state level is -- is being led by HFS with public health participation.

The -- but most typically, what I discuss at legislative update is the lay of the land in Springfield. So let me tell you about some of the what's going on, and then I want to make sure I get back to Dr. Kruse's question and then Kevin's questions about how the State Board of Health might best be involved.

The legislature, when it starts in session, as I alluded to earlier, you know, resets the clock and introduces new bills. I believe between the House and the Senate, they've probably got over 4,000 introduced so far. And as you may know, what we do here is Cleatia does a first pass on every bill that's introduced to determine whether it's something our agency should be monitoring, and then a triaging to sort them out to the different programs at the agency for review. And at the same time, we also have initiatives of our own, affirmative initiatives. Oftentimes we're in defense or in alliance. Occasionally we're on offense.

And -- but again, we prepared for this session, and our affirmative agenda in coordination with the governmental affairs office of the previous Governor, and the last several years our direction from the previous Governor has always been very restrained. We would compile a list of 15 or 20 things we wanted to do, and we would be told, well, just do these three. The rest perhaps next year.

So our affirmative agenda is going to sound rather crypt to you when I describe it, but I'll describe it for you nonetheless.

One is to broaden the basic statute relating to public health and response. Right now, the statute mandates that the Department investigate the causes of dangerously contagious or infectious diseases and the health effects of same, and the bill -- it's House Bill 3922, would broaden that to include biological, chemical, radiological or nuclear events. So this is a preparedness related issue to make sure that our statute more broadly identifies the -- the health effects that we are supposed to investigate, to pick up the ones that might be related to, you know, terrorist type incidents. That's House Bill 3922. It's sponsored by Greg Harris, and it was approved by

the Human Services Committee yesterday, and it's in the House on short debate.

The second bill is House Bill 805. It's also a preparedness related bill, and currently there's a statute on the books that provides that we should maintain a registry of all active duty health care professionals in a broad listing of categories, and provides that we may access it in the event of an act of bioterrorism or other public health emergency. And we would like to broaden the statute to allow us to access it for purposes of planning for the possibility of such an event, and that's what House Bill 805 would do. That is sponsored by -- I've lost -- I didn't print it out. That's House Bill 805.

We have two bills in the Senate. One is Senate Bill 1254, and that would extend the sunset date on the Structural Pest Control Act from December this year to January of 2019, almost ten years from now. Those of you who follow the ups and downs of the Structure Pest Control Act know for some reason it ran into a hiccup last year and was allowed to sunset, and we got that fixed by an unsunsetting, but that only extended to December of this year, and we would like to proactively get it extended for another ten years

so that doesn't happen again.

And then the fourth one is Senate Bill 1918, and it -- it addresses a little quirk in the law. You may or may not know, we license persons who operate migrant labor camps, and our current statute says that we should issue the license on a calendar-year basis. And that has led to a situation where our licensing activity may have nothing to do with when the camp is open, and so we would like to change that so that the licenses are issued -- they have to obtain a license prior to operating, rather than just on an annual calendar-year basis.

As I said, that's not a very weighty set of affirmative initiatives, but those are our initiatives. Let me detail a little bit for you the process we go through and why -- off the top, I'm having a hard time figuring exactly how to meld the State Board of Health -- or the Policy Committee into that. When Cleatia identifies those bills that have some aspect that we should monitor, the list -- Cleatia, I haven't checked with you this year, it's probably several hundred, isn't it, three or four hundred?

MS. BOWEN: I think it's about 268.

CHAIRPERSON PHELAN: She's not sure.

MR. CARVALHO: Well, it will be 300 before the session is over, I can assure you of that. And they get all -- sent out to all of the program, they write up an analysis that's, you know, a working draft of a position paper. All of those are then submitted to me in my capacity as the policy director, and I review all of those again, and, you know, and then I -- I share those with Denise Gaines (phonetic), who is our legislative person, Cleatia's boss. And then Denise runs all of our positions by governmental affairs in the Governor's office, and we don't take a position on legislation in the General Assembly until that process has all been done, in particular the vetting by me and the vetting by Denise and then the vetting by the Governor's office.

And so from time to time in the past, probably some of you have inquired of us directly, you know, what's your position on this bill or that bill, and unless all of those steps have been gone through, we're -- we don't indicate what our position is. And because it's past history, I'll give you an example. We might write up a position on medical marijuana that takes a position in one particular way all the way

through the director's office, and then the Governor's office tells us what our position is. So -- and that's understandable. I mean, we are a hierarchical organization.

Now, what I described to you in slow motion takes place oftentimes over two days or three days or the weekend. Cleatia on Friday gave me a list of seven or eight bills that she needed my position on by noon on Monday, and then Denise right now, who often attends these State Board of Health meetings, is over at the capitol, and I think her week, if I remember her e-mail, she's going to 78 -- she's got 78 different bills that are being heard this week that she's trying to coordinate injecting our position into the process.

So -- and that's really -- we're right in the heart of things, because as you all know, first bills are heard in the committee, and then nine times out of ten, they pass out of the committee as is, or even if you identify problems with them, they pass out anyway under an oral agreement to, quote, work with the sponsor on the issues that have been raised, either by us or by other advocates. And the rest of the session is Denise and Cleatia and sometimes me

trying to interact with all of the sponsors of all of those pieces of legislation that we're following where we've identified issues.

And you know, truth be told, probably at least half of the time we do identify an issue that we need to raise with a sponsor, sometimes a fundamental issue, sometimes just a drafting issue. You know, you've amended the wrong section. This bill already exists. It's over in another part of the statute. Or, you know, a significant one like the lysosomal storage disorder bill that I mentioned to you earlier, or you probably recall me having talked to you about the travails of the Thimerosal bill. And so some of them are quite time consuming. Some of them are less time consuming.

So I go in that great detail of the process, because I'm certainly open to suggestions about how the State Board of Health or a committee of the State Board of Health could get involved in that process, but the timelines are very daunting, and the reality is that our positions aren't really our positions until they've been vetted by the Governor's office.

CHAIRPERSON PHELAN: Do those all arrive electronically, Cleatia? Do you get those

electronically?

MS. BOWEN: Yes.

CHAIRPERSON PHELAN: Jerry?

DR. KRUSE: Do I get them electronically?

CHAIRPERSON PHELAN: No. Any questions?

UNIDENTIFIED SPEAKER: David?

MR. CARVALHO: Yeah.

UNIDENTIFIED SPEAKER: I'm sorry. I couldn't hear if a discussion was going on. If there was a way to at least keep us in the loop, since everything we're going to be giving you would be advisory anyway, it isn't necessary, I don't think, that we all get together and deliberate over them, but if you pass them by us, there may be input. For instance, each of us may be looking at certain specific bills. I was very interested in this Disphenol A bill, and then there was one on pesticides that was being discussed. So if like Cleatia sends the stuff to you, if it is electronic, if it was passed by us, perhaps individuals could pick out the things that they are most interested in following through with and then give you a few comments also electronically.

CHAIRPERSON PHELAN: Herb?

DR. WHITELEY: Dave, where do these bills

originate from? They come from a specific legislator, but that's derived from some constituent that's been in their office saying I have this problem, and they jump onto it? Is that -- because, I mean, we deal with the same thing on the med side, there are all these bills that are being introduced, and most of them --

MR. CARVALHO: Yeah. Often what happens is exactly what you just said. You know, for example, you heard earlier in the call, IPHI, in connection with the summit from the SHIP, is developing three initiatives, and they go to Beth Coulson or they go to Senator Delgado and say can you introduce this bill.

Now, truth be told, Cleatia and I are on the inside in dealing with these legislators. Sometimes you go to them with your comments on a bill, and I hope I'm not telling tales out of school, but the legislator will say, oh, don't worry, I just put that in because somebody asked me to. I'm not really moving that, and so we relax. But oftentimes, it's a constituent, and the -- the outcomes are all over the map.

We've had bills where a single constituent of a single senator comes to them with an issue, and

we will show up at committee with why we're against it, our doctor expert who is against it, our stack of studies from the CDC and NIH that say against it, and the sponsor will sit there with the constituent and even more persuasively with the constituent's affected child, and the committee will vote in favor of the bill seven to nothing. So it really -- the bills -- sometimes the bills are initiated -- again, I guess I'm telling tales out of school.

If an agency has a number of things on its agenda, and you know there are things that are identified by the Governor's office as things that can overtly be part of your agenda, those are the ones identified to you. The other ones, they will sometimes say, well, if you find a sponsor who wants to push it, sure, go ahead. Just don't make this part of your overt agenda. So sometimes legislators sponsor bills for agencies that way. And sometimes legislators have their own, you know, issues as well.

Now, I should tell you, you know, this is Illinois. I went down to a conference, to Minnesota once, and I said, you know, how do things work there. And they said, well, at the start of the session, our Senate public health committee gets together, all the

Democrats and Republicans, and they kick around a bunch of ideas and then identify six or seven that they think are worth moving, and then those get moved. And they have the advocacy groups in the room and the Department of Public Health in the room, and they have a nice full and frank discussion and they set an agenda for the year.

CHAIRPERSON PHELAN: All on the same page.

MR. CARVALHO: Yeah. We don't have anything close to that here.

UNIDENTIFIED SPEAKER: I'm getting ready to call the moving company as we speak.

DR. ORRIS: On the other hand, they only have one senator.

DR. WHITELEY: Yeah. We have one and a half.

DR. KRUSE: What David says only reinforces why it would be important for us to see these things, because what we would have to say about these bills -- and it may fall on deaf ears, but what we would have to say about that, bills would not be vetted by the Governor's office. I mean, we can evaluate them and make a recommendation, or at least make some kind of statement.

I will tell you that a few months ago, one

of my colleagues came to me asking me when did the State Board of Health deliberated about cystic fibrosis screening on the screening battery, because she had been involved with the case. And it all gets very complicated, but I won't go into the details, and I said, whoa, I don't remember seeing that. So we looked on the internet and saw when it was passed, and it almost felt like a little egg on the face of the State Board of Health having not deliberated about that before some significant screening test like that was added to the battery.

CHAIRPERSON PHELAN: Right.

MR. HUTCHISON: There's been a couple of questions, I think Dr. Orris kind of mentioned it too, in terms of if -- in the journey, and it's a very dynamic journey here in Illinois how these bills get passed and what happens to them, but perhaps the low hanging fruit here is when Cleatia looks at those initial 268, if they're -- as they're pushed out without the analysis, just the fact that they have impact on public health, maybe that's the point where electronically that could be shared with members of the State Board of Health, and we become -- we have then situational awareness, and we can take it from

there. Because we understand that a lot of things are going to change and happen.

We respect the process of the state staff, and the Department has to look at things and the vetting process internally, but in an advisory capacity, A, we would have, as Dr. Orris mentioned, at least some ability to give some comments as individual professionals throughout the state, but also, this would not make it awfully too onerous on state health department personnel, who are very stretched, and it's a very dynamic and very quick moving process.

And I think the other thing that we have in terms of strength, as you mentioned, the institute is introducing legislation, and there is a working relationship with their policy committee. So we are kind of involved at a policy committee level, and maybe we need to make sure when we push those out to the other members of the Board, I think we probably already are, but there are some in reach that we can already do within our own state board, but at least the first step might be push the button and just send it out, you know, that initial screening of the 6 or 7,000 bills, 268 are public health related, that those could be disseminated as they happen to Board members.

Then it's on us to look at them and deal with them as we deem appropriate.

MR. CARVALHO: Why don't I suggest this: Does somebody remember -- I should, and I don't -- how many members of the Board of Health there are?

MS. BOWEN: Thirteen.

MR. CARVALHO: Thirteen. Okay. So a quorum is seven, and a majority of a quorum would be four. So if -- you don't want to establish a committee, because a committee has its own Open Meetings Act requirements, but if you had a work group of three that could explore this further with Denise and me and my chief of staff -- I have to think through how we could do this. I don't want to do it on the spot, but if I say wait until the next meeting, your next meeting, the General Assembly is gone. And I don't even necessarily want to wait until the next meeting of your Policy Committee, because that's going to be down the road.

So if there were three of you who wanted to work with me and Denise and Jessica Pickens, our new chief of staff -- and the reason why I include her is Jessica used to be one of those people in the governmental affairs office in the Governor's office.

She's now our chief of staff. So she's intimately familiar with the process, and we could figure out what -- what we can make work on this. Karen, you're the chair, and you can see better down there. If you can see who might be interested in that.

CHAIRPERSON PHELAN: Is there any one interested in joining me?

DR. ORRIS: I would volunteer for sure.

DR. KRUSE: I could do it. I'm here in Springfield a lot, actually.

DR. WHITELEY: I could do it.

CHAIRPERSON PHELAN: Okay. So we have Peter, Herb and Jerry.

DR. ORRIS: Could you also comment on how you handle the shell bill routine? Do you get hit by that a lot?

MR. CARVALHO: Okay. One of the things that Cleatia does is identify bills that are shell bills. And everybody -- well, a shell bill is a bill that doesn't do anything. It exists as a shell for a future amendment that one can anticipate is coming down the pipe. So for example, if there's a bill that says to add a provision to the Public Health Code to refer to the State Board of Health as the State Board

of Health instead of State Board of Health, that's a do nothing bill. But the purpose of the bill is to have something in the legislative process onto which a germane amendment could be added.

So for example, there's all sorts of bills right now that make a minor change to the Illinois Health Facilities Planning Act, and one can anticipate that that's around so that someone is developing an amendment somewhere, someplace, that they aren't quite ready to reveal to the public, and -- but they would move -- have the shell bill around so that -- because there are deadlines for processing legislation in the General Assembly, and so you might not have been ready to show your hand when the deadline for bill introduction was coming, but you later in the process are ready, and so you've got now a bill that you can amend to do what you wanted.

What Cleatia does is she identifies shell bills and sends a notice to the likely affected office within the agency and says just for you to monitor there's this shell bill related to your program. And then what Cleatia and Denise do, and this is -- I hope you appreciate how complicated this is -- they have to monitor every amendment that everybody files to any of

the 268 bills that we're monitoring, because at any moment any bill could turn into any other bill. I mean, you could have a bill that looks like it's not doing anything of any consequence, maybe not even a shell bill, maybe it's a real bill, but it's of minor interest, and then suddenly some other weighty thing gets put upon it.

And the rules of the House and the Senate make it possible for that to happen in a flash of an eye, because while there are rules that say there are certain posting requirements where things have to be posted for a certain period of time before they can be heard, there are other rules that allow the posting requirements to be suspended. And so we sometimes have plenty of advance notice that something is happening, and sometimes we find out that morning that something is being called that morning that takes a bill in a totally different direction.

For example, last year, we had received notice that there was going to be a bill, an amendment to prioritize receipt of vaccines that are Thimerosal free to infants in our program. I had worked out that amendment with the sponsor. I was fine with that amendment prioritizing the delivery of Thimerosal free

vaccines to children under two. And I got to the committee, and the amendment had become one to ban Thimerosal in all vaccines.

So you can imagine -- do the math. If you take 268 bills, all of which could be amended at a moment's notice with a germane amendment, all of that is something that Cleatia and Denise are monitoring, and that's -- so that's in answer to your question, Peter, how do we track shell bills.

DR. ORRIS: From your end, not terribly easy. On the other end, I understand that the leadership has something to do with allowing certain of these things to morph.

MR. CARVALHO: Let me explain how that works. The rules provide for a committee -- at least in the House, it's called the Rules Committee. And this is all -- if any of you learned civics class 20 years ago, it has all changed. It used to be a much more open process. But about ten years ago, they changed so that every step of the way, just about, has to be approved by the Rules Committee. So you introduce a bill, it goes to Rules Committee, and then they decide which substantive committee to send it to.

You want to introduce an amendment to your

bill on the floor, the amendment goes to Rules Committee and they decide whether or not you're allowed to issue the amendment. You want to file a motion to discharge a bill out of committee, that motion has to go to the Rules Committee to decide whether you're allowed to do the motion on the floor.

So the Rules Committee has total control over the movement of -- of bills through the process, and the Rules Committee, I believe, consists of three legislators, two appointed by the speaker and one appointed by the majority leader, so that the speaker and the majority leader don't have direct control, but their direct appointments of their very most loyal people on the Rules Committee have total control. And then on the floor of the House, the speaker also has control over what bills are called in what order. So these are the two principal ways -- and then finally, the leadership has the right to replace, even for purposes of one bill, any member of his party on any committee.

So if there's a bill before a committee -- let's take an example, if there is a gun control bill before a committee where the leadership wants the bill to pass, but they know the composition of the

committee won't accommodate that, they might replace three people on the committee for just that bill, and then the bill passes. So the leadership, one can never underestimate the power the leadership has to control the process.

CHAIRPERSON PHELAN: Any questions? Cleatia, I asked, those come to you electronically. Do you also get all the changes every time there's anything that's happening with it, and if it moves very quickly, or is someone physically there --

MS. BOWEN: Well, we normally get them -- I usually track the amendments to the bills, and then I have to send them out to the various programs to see what their input is as it relates to the amendment. So...

MR. CARVALHO: Yeah. The one thing to keep in mind, as daunting as this sounds, this used to not be on electronics. You used to have to hang out at the bill room and grab paper copies of stuff as it got filed.

MR. HUTCHISON: David, just one of the issues, could you give us just a brief update on the Smoke Free Illinois Act implementation? I know that the law has been enhanced in terms of its enforcement. I know

IDPH is going to be doing some training of locals, but other members of the Board might be interested in IDPH's role in rolling out the implementation of the newly improved Smoke Free Illinois Act.

MR. CARVALHO: Well, this is the part where I admit that I have not been in the office 10 of the last 12 days. I'm afraid I've lost touch with exactly where we are. I know, as you say, the bill passed. Cleatia, is Tom Schafer there, or Susan, do you happen to know where we are on the rules?

MS. MEISTER: Tom Schafer is not here. As far as rules are concerned, I don't have any updates.

MR. CARVALHO: Because as Kevin mentioned, the statutes that we wanted to have fixed so that we would clarify the due process. I'll tell you what I do know, and it's not comprehensive. We are gearing up to set up the appeals process that we are now supposed to conduct for people who have been fined for violating the law. The law has now been changed to clarify that they do have an appeals process, and I know at some step, and maybe it's the very first step of the process, we are supposed to have an administrative hearing set up. So we're gearing up to do that. But I'm sorry to say I have not learned what

we have done in the last couple of days to do this. Maybe Cleatia can grab Tom.

MS. BOWEN: I'm trying to locate him for you.

MR. CARVALHO: Thanks. He's probably in Gary Robinson's office.

CHAIRPERSON PHELAN: Are there any other questions? Any new business?

MR. CARVALHO: One thing to tell you. I think I told somebody, by the by, one of the bills that is working its way, although it actually got put into a subcommittee yesterday, is the bill to extend the life of the Health Facilities Planning Board. And that was the result of a task force that met for the last year or so. One of their recommendations was that to correct the problem, that the planning board has never actually done planning. It simply reviews applications for CONs.

And so the legislation would create a Center for Comprehensive Health Planning in our agency, although the head of the center really wouldn't be picked by our director, and that center would develop a health -- comprehensive health plan, and on its way to adoption, it would be submitted to you, the State Board of Health, for your review. So that direct --

the legislation has been drafted.

I mentioned it to you both for the general topic and because your name has been interjected into the process. I don't know where that is going. I think it is that the health planning board expires July 1st if no action is taken, so I suspect something is going to happen. The bill was heard in committee yesterday and put into a subcommittee, which is usually a death sentence for a bill. But as I mentioned at the very beginning, you can kill a bill, but you can't kill an idea in Springfield. So that concept could come back on any shell bill, or even that bill could come back out of the subcommittee if the stars align.

DR. KRUSE: David, does this bill focus mainly on facilities planning, or does it also include a broader idea like workforce planning or organization of systems?

MR. CARVALHO: On paper, at least, the Center for Comprehensive Health Planning is asked to view the issue of planning very broadly. Because as suggested by your comment, you know, buildings don't treat patients; health care providers do. And so one can't look at the issue of comprehensive health planning

without taking into account everything. Now, the reason why I say "on paper" is the legislature is very reluctant to give any tools to the Center for Comprehensive Health Planning, and so the legislation sort of makes it a recommending type plan, so that the ability to decide what, if any, tools should be used to effect the plan are -- the choice of tools remains in the legislature.

CHAIRPERSON PHELAN: Excellent. Any other business? Thank you, David.

MR. CARVALHO: Sure. And I apologize, I didn't at the beginning, for not being able to participate in person. There was a two-day health planning board meeting the last two days I was at, and it went much later than I anticipated, and I couldn't work the turnaround to get down there in time.

CHAIRPERSON PHELAN: This works out beautifully. Actually, we would all like one of those little cameras in our office. That would be nice.

DR. ORRIS: As a matter of fact, as long as we're talking about this, again, could we try to get this telecommunications stuff so at least this one place up here in Chicago and one down here?

MR. CARVALHO: Peter, actually I am at the video

conference here in Chicago.

DR. ORRIS: Oh, all right.

MS. BOWEN: I've got Tom, David.

MR. CARVALHO: Okay. Tom, if you could take a moment just to update people on --

MS. BOWEN: He should be coming through the door.

MR. CARVALHO: Oh, okay.

MR. SCHAFER: What can I do for you?

CHAIRPERSON PHELAN: Can you identify yourself for the court reporter?

MR. SCHAFER: Oh, I'm sorry. Tom Schafer. I'm the Deputy Director in the Office of Health Promotion.

MR. CARVALHO: The question, was what's the status of Smoke Free?

MR. SCHAFER: Very good, I think.

DR. VEGA: She needs your name spelled.

MR. SCHAFER: Oh, I'm sorry. S-C-H-A-F-E-R. I don't know -- I'm sure you all understand the history of this bill, so I'll jump ahead a little bit.

MR. HUTCHISON: The question was, you know, where are the IDPH in terms of implementation now without the DMD. New and improved version's there with some enforcement capability. I mentioned to the Board, I know there's some training coming up, but I -- you

know, if this has been a big issue for the state board and our Policy Committee for several years, and now that the new law is in place, we're interested in seeing what's -- where is IDPH on this, how do you see this being rolled out and implemented, coordination, not only local health departments, but also local law enforcement, since they're going to be named in the act as enforcers, along with the state health department and us as local health departments.

MR. SCHAFER: Sounds like Kevin could do this.

MR. HUTCHISON: I'm just asking the questions. I don't have the answers.

MR. SCHAFER: Well, the bill, as you all know, was the first that was signed by the Governor, the first bill that he signed when he took office. So we were very happy with that. Without his signature, it was -- the former Governor was talking about an AV on that, which then would have meant that the bill would have died and we would have been back to where we were. So from that standpoint, we're thrilled that this bill went into effect.

I'll be candid in that I think everybody realizes the initial bill had a number of flaws in it, so this bill was an attempt that we were involved in

starting last summer to correct some of those problems. We think that it's probably corrected most of them. I'm sure others will come up as time goes on. But from our standpoint, one of things that was put in there is we don't have to do a rule. As I'm sure you're well aware, we didn't do real well in the rule process a year ago for a number of reasons, most of them political. But -- so this time I met with our chief counsel. We don't believe a rule is necessary. But as we get into this, we may find that it is necessary. So we're keeping our fingers crossed.

But probably the key thing that everybody talked about was that there wasn't a hearing process. Then some people suggested since it didn't have that, it was unconstitutional. We made sure that that provision was in this bill. So what that means to us and our poor legal staff is that we are now the people who will be doing all administrative hearings on anybody that wants to appeal the fine. It is not a criminal matter. It's a civil matter. So it will go -- it has to go before an attorney, so it will be either one of our staff attorneys or one of our Administrative Law Judges.

And at this point in time, we're kind of

considering this other duties as assigned. We get a lot of those in state government these days, other duties as assigned. We have no way -- and our chief counsel asks me this all the time, how many of these are we going to have. I don't have any way of knowing. Kevin may be able to estimate, but we cannot. We look at the last year, I think I may have this a little off, but we collected as an agency our share of the fines, which is 50 percent of the fines, we collected $1,500. So there weren't a lot of fines issued. There weren't a lot of fines paid. Whether enforcers at the local level are waiting, you know, waited for this new law to start writing more and more tickets, we don't know. We'll find out.

But for the time being, the way the law is written is that we will hold an administrative hearing in our regional office that's closest to where the ticket was written. If, however, we find that -- we can't use Kevin's too much because we're too close to him in our regional office down there, but let's say that Danville wrote a hundred tickets, Vermillion County had a hundred tickets, and Champaign had one. We would go to Vermilion County and hold our hearings there.

So we'll work on this as time goes on, depending on what we see. That's probably the key provision that I think everybody was waiting for, is the key provision at least as far as manpower is concerned for our agency. We think we'll be able to handle it, you know, with existing staff, but we don't know.

DR. VEGA: I've seen more enforcement in the last month where I live in Peoria, but I want to ask: So are the offenders the establishment owners, or are they the customers, or both?

MR. SCHAFER: Both.

DR. VEGA: And on what grounds do you anticipate appeals? What are the grounds of appeals?

MR. SCHAFER: Well --

DR. VEGA: One or two comments.

MR. SCHAFER: Probably I can give you a better answer for business owners. What individuals will say, you know, no, I really wasn't smoking, yes I was, I don't know. For business owners -- and it gets a little hard for whoever is the enforcer, as far as the business owner, if they attempt to stop the person and then they continue to smoke, we would suggest to the enforcing agency that the business owner shouldn't be

written up, now, if they tried. I mean, there -- if they called the police and had them come in, in my mind we shouldn't hold the business owner accountable, but -- for the individual who refused to stop smoking and wouldn't leave, they should be given a ticket.

So there may be some arguments from business owners along that line, that they attempted to do some sort of enforcement, and the individual just didn't do that.

I know there has been some cases in your neck of the woods, and I would hate to come up and try and guess, because people are very creative when they appeal things. I think there will be appeals from people, and they will just show up and -- like traffic tickets, they will hope that the enforcing agent or the person who wrote the ticket won't show up. That's probably -- I wouldn't want to say that too much publicly, but that's probably my biggest fear, is we are going to be imposing on local health departments, that they're going to have to show up. Otherwise it's going to be thrown out.

So, you know, use another example, I think about, you know, Galena and out in that Jo Daviess County, they're going to have to come all the way to

Winnebago County. I used to live in that area, I know there's a -- that's a heck of a trip to make. So we're going to be asking the people who wrote the tickets to make that drive, which is two hours at least.

DR. VEGA: That must be done in person? Can't be done --

MR. SCHAFER: No, has to be done in person. So those are things that, I mean, I have concerns about, but, you know, we talked about this as an agency, maybe possibly doing contract attorneys at some point if we need to go into other counties. Some of the sponsors suggested that we do -- we have attorneys in 102 counties. I don't know where we would get that money. Some suggested that we could use the money from the fines. As we saw in the last year, $1,500 isn't going to hire too many attorneys for us. So you know -- and I mean, you all understand where we are in the state budget.

We put in about two years ago for enforcement on this a fairly hefty price tag, and it was over a million dollars, some of it which was to help the local health departments, because they're the ones that get stuck with this. We were -- we were

told that there's just no money. I think we're going to be told that on a number of things as time goes on. We'll hear more next Wednesday. But there's no money that is being offered to us. So I mean, there are those problems.

We would love to be able to make it easier for everybody involved, but I don't see how we can do that. The law specifically says we have to have it in the regional office. We will follow that. It does give us an out if we want to try to hold it in accounting, we can do that, too. But for the time being, we want to see how this proceeds. We want to see what kind of experience we have, and then we'll have to make a decision further down the road. But as with everything, resources are an issue.

I mean, Kevin mentioned this. We are developing a standard ticket. That's something that a lot of people have asked us about. I mean, the law is very specific, particularly this new one, on what has to be on that ticket. Some communities have said they don't want anything from us. They don't want the state to dictate to them, which is fine. So we're going to develop a sample. People can use it if they want. They can use their own, just so long as they

have certain elements on it. So we are going to have -- hopefully we will have that -- we're having a meeting with local health departments on the 18th of next week. Hopefully we'll have that.

We are also developing an appeals form so all the local health departments will have it. If a person does get a ticket, they will be given this form that they can fill out that says that they want to appeal, sign it, they need to get it in to us. My office will -- at least for the time being, we will do the scheduling with the regional health offices and with the Administrative Law Judges. And -- but there's no time frame on the hearing, so it won't be, you know, within a week or two. It probably will be a little longer, but it will depend on resources on that too.

CHAIRPERSON PHELAN: Let me ask you about what has happened in the past. Several people were issued violations, fines. They had an option whether they wanted to pay it, or specifically whether they wanted to write in or call in or electronically request a hearing; is that correct?

MR. SCHAFER: Well, the people -- the appeal's before they have to go to court. There was not an

administrative hearing process unless there was a local ordinance in that there was something that was put in place that was stricter than the state law. So there were some communities that had an appeal process, and they went through however they do that on, you know, municipal problems.

CHAIRPERSON PHELAN: So it was handled individually by all the different --

MR. SCHAFER: Uh-huh.

CHAIRPERSON PHELAN: Okay.

MR. SCHAFER: If they had an ordinance stronger than the state's. If it was a state -- based on our law, they had to go to court. That was one of the big things that everybody complained about, was they had to get an attorney, most likely they'd appear before a judge. The court system wasn't particularly thrilled with that, but that's the way the law was written. This one, the new law takes that out of the criminal courts and puts it in civil court, and it allows us to handle the administrative hearing. If we deny it, then it does then go into the court system.

CHAIRPERSON PHELAN: Okay.

MR. SCHAFER: But there is a place that they can go that shouldn't cost them money, and they can appear

before a hearing officer.

CHAIRPERSON PHELAN: So we have no statistics as to how many people have totally ignored the fine?

MR. SCHAFER: Totally ignored it and not paid?

CHAIRPERSON PHELAN: Right. And just waiting to --

MR. SCHAFER: That would be done on a local level, and I mean, their recourse is to go to court and get a judge to, you know, order them to pay and have the sheriff or local police serve them. But I don't think there's been too many. I mean, I've read about some in the paper, I think in the Peoria paper, and there has been some people that have done that. But I think it's a small number. I don't think it's real huge.

And complaints and such were -- we've had a year and two months now, a year and three months, we've probably had about 6,000 complaints. Some are a little annoying from the standpoint that you have a lot of bar owners that like to fight with each other and call up and say, hey, the guy down the street is violating it, you know, vice versa. But some -- obviously that from the standpoint it was a new law, people getting used to it. We've had a little uptick

since the new law, and there was more attention in the media. But honestly, I mean, I don't know about all of you, the places that I go to, the restaurants, I don't go to that many bars, but the places that I visit, bowling alleys, there's no smoking. I mean, it's just --

MS. O'SULLIVAN: Wonderful.

DR. KRUSE: It's great.

CHAIRPERSON PHELAN: It is.

MR. SCHAFER: It's so nice. But you're going to have -- there's some out there, we've read about them in the paper, where they say we're never going to change, come get us. We had one in the front page of Chicago Tribune last year, the owner of a bar in Christian County said he was never going to comply with the law. You're going to have those kinds of people.

CHAIRPERSON PHELAN: Interesting.

MR. SCHAFER: We'll eventually get to them, and they used to collect money from the people in the bar, figuring that they will pay the fine if they get a ticket. But we figure that with the way the bill is written, for a business owner it's 250 the first time and 500 the second, it's 2500 the third. They're

going to start running out of money in their kitty to pay those fines.

CHAIRPERSON PHELAN: Absolutely.

MR. SCHAFER: So, I mean, we're -- as much as there are problems on this hearing enforcement side, we're absolutely thrilled with it. From our department's standpoint, I think it's one of the premiere laws that we've had for public health in decades. So we're very happy.

CHAIRPERSON PHELAN: Thank you, Tom. We appreciate you talking to us.

MR. CARVALHO: Thanks, Tom.

CHAIRPERSON PHELAN: No further business. Thank you.

STATE OF ILLINOIS)
) SS
COUNTY OF SANGAMON)

I, Christina J. Riebeling, do hereby certify that I am a Certified Shorthand Reporter, Certified Court Reporter and Notary Public within and for the County of Sangamon and State of Illinois, and that I reported by stenographic means the proceedings and had on the hearing of the above-entitled cause on March 12, 2009, and that the foregoing is a true and correct transcript of my shorthand notes so taken.

Dated this 25th day of March, A.D., 2009.

_____
Certified Shorthand Reporter
Certified Court Reporter
Notary Public
(CSR # 084-004006)

My commission expires:

November 16, 2010